DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted 10/16/06 B. Dawson Letter Sent.

PRINTED: 09/25/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295023	A. BUILDING _____ B. WING _____	09/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON CONVALESCENT CENTER	2898 HIGHWAY 50 EAST CARSON CITY, NV 89701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey conducted at your facility on 9/11-9/14/06. The census at the time of the survey was 68. The sample size was 15. One complaint was investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. CPT #NV00012478 was a facility reported incident involving a resident injury and lack of resident assessment. The injury was substantiated, however, the lack of resident assessment was not substantiated. No deficiencies were cited.	F 000		
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of resident records, it was determined that the facility failed to develop, revise or update the care plans necessary to provide quality care for 3 of the 15 residents in the sample. (Residents #10. #14 and #7)	F 282	F 282 Resident #10 corrected, see attached F 315 a. Resident # 14 corrected, see attached F 315 b. Resident # 7 (is res. #27) see attached F 315 c.	Date Deficiency 10/11/06 10/11/06 10/11/06

RECEIVED
OCT 11 2006
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 10/04/06

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 Findings include: Resident #10: The resident was admitted to the facility on 3/22/06. She had previously resided in an adult group care setting. Diagnoses included dementia, convulsions, depressive disorder and hypertension. A review of the Medium Data Set (MDS) dated 6/30/06 indicated that Resident #10 was incontinent and on a toileting program. A review of the resident Cardex that was used to convey the specific care of the resident to the Certified Nursing Assistants did not indicate that the resident was on a timed voiding program. In an interview with the B wing charge nurse at 9:30 AM on 9/13/06, she confirmed that the timed voiding program was not indicated on the resident's bladder and bowel information. However, data sheets in the resident record indicated that the resident was being toileted, but the data was not being recorded according to the directions for a timed voiding program. Review of the care plans indicated two active care plans regarding urinary incontinence. One, dated 3/22/06, indicated that the resident was to be placed on a three day bowel and bladder assessment to determine the potential for an individualized program. There was no indication as to why the assessment was to be done, i.e. decreased urinary incontinence, new admit, etc., if the assessment was completed or that the care plan was resolved. In an interview with the Director of Nurses and the Assistant Director of Nurses at 2:30 PM on 9/13/06, the ADON indicated that the care plan should have been resolved and discontinued.	F 282	All residents have the potential to be affected by the deficit practice of failure to develop, revise, or update the careplans for B & B program, necessary to provide quality of care for three of fifteen residents sampled. For correction, see F 315 Updates and careplans will be done as indicated.	

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F 282	Continued From page 2 A second care plan, addressing an individualized toileting program, was dated 3/27/06. It identified that the toileting times were 2:00 AM, 6:00 AM, 9:00 AM, 11:00 AM, 2:00 PM, 5:00 PM, and 9:00 PM for Resident #10. It was noted to be reviewed on 6/27/06 and 9/21/06, but there was no indication of any revision, or any indication of progress toward or lack of progress toward the stated goal of improved incontinence. The column entitled "goal analysis" indicated only that the program was initiated on 3/27/06 and that the plan of care was continued for 90 days on 6/21/06. Bowel and Bladder Programs sheets were present indicating that the resident was being toileted, but in reviewing the documentation it was not clear that the concept of timed voiding was clearly understood or that it was being enforced as intended in the care plan. Cross reference to Tag F315. Resident #14: The resident was admitted to the facility on 12/5/02, with diagnoses including dementia, depressive disorder, osteoarthrosis, anxiety and trigeminal neuralgia. She was alert but cognitively impaired. Resident #14's records were reviewed on 9/12/06. Physician orders for September 2006, indicated the resident was to be placed on a timed toileting program which was to be monitored weekly. Her care plan indicated she was on an individualized bowel and bladder program. The care plan indicated that the toileting program was last reviewed on 8/16/06 and was to continue for 90 days. It also indicated that the program was to be monitored weekly.	F 282		

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F 282	Continued From page 3 The facility policy was reviewed and it revealed that the resident's progress or lack of progress was to be documented by the nurse on a weekly basis along with any adjustments to be made to improve the resident's potential to succeed. Resident #14's records did not reveal that the nurse had addressed the resident's success or lack of success with the program or identified any adjustments to be made on a weekly basis. Resident's #14's record revealed that her percentage of urinary continence ranged from 25.5% continence to 52% continence during June, July and August of 2006. No weekly nursing documentation was found to indicate the resident's performance was evaluated to determine why the resident's performance varied and what interventions might make the resident more successful. An interview with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) on 9/13/06 at 2:30 PM, revealed that the restorative bowel and bladder weekly progress notes were signed by a nurse but there was no place on the form for the nurse to document the evaluation of the resident's performance. The ADON indicated that she reviewed the toileting programs at the end of the month, however, there was no documentation found that indicated the resident's performance had been evaluated. Resident #7: The resident was admitted to the facility on 10/14/02, with diagnoses including dementia, cerebrovascular disease and a fractured femur. She was cognitively impaired. Resident #7's records were reviewed on 9/12/06. Physician orders for September 2006, indicated	F 282		

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F 282	Continued From page 4 the resident was to be placed on a timed toileting program which was to be monitored weekly. Her care plan indicated she was on an individualized bowel and bladder program. The care plan indicated that the toileting program was last revised on 7/12/06 and was to continue for 90 days. It also indicated that the program was to be monitored weekly. The facility policy was reviewed and it revealed that the resident's progress or lack of progress was to be documented by the nurse on a weekly basis along with any adjustments to be made to improve the resident's potential to succeed. Resident #7's records did not reveal that the nurse had addressed the resident's success or lack of success with the program or identified any adjustments to be made on a weekly basis. Resident's #7's record revealed that her percentage of urinary continence ranged from 22% continence to 62% continence during June, July and August of 2006. No weekly nursing documentation was found to indicate the resident's performance was evaluated to determine why the resident's performance varied and what interventions might make the resident more successful. An interview with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) on 9/13/06 at 2:30 PM, revealed that the restorative bowel and bladder weekly progress notes were signed by a nurse but there was no place on the form for the nurse to document the evaluation of the resident's performance. The ADON indicated that she reviewed the toileting programs at the end of the month, however, there was no documentation found that indicated the resident's	F 282		

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F 282	Continued From page 5 performance had been evaluated. Cross reference to tag F315.	F 282		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interviews, observations and resident record review, it was determined that the facility failed to provide adequate services to restore as much bladder function as possible for 3 of 15 residents. (Residents #10, #14, and #7) Findings include: Resident #10: The resident was admitted to the facility on 3/22/06 with diagnoses of dementia, convulsions, depressive disorder and hypertension. She had resided in a group home setting previously. Review of the resident record revealed a care plan dated 3/37/06, indicating that a timed voiding program had been initiated for Resident #10. It was to be continued with weekly monitoring for 90 days. A new order was written on 6/21/06 to	F 315	F 315 Resident #10 corrected, see attached F 315 a. 10/11/06 Resident # 14 corrected, see attached F 315 b. 10/11/06 Resident # 7 – Resident # 7 on identifier list is a male that was admitted on 4/27/06 with no diagnosis of fracture. Believe this to be resident # 2, a female resident who was admitted on 10/14/02 with diagnosis of fracture. Resident # 2 corrected, see attached F 315 c, 10/11/06 All residents have the potential to be affected by the deficit practice of failure to provide adequate services to restore as much bladder function as possible for 3 of 15 residents. The corrective action is that all residents on the B & B program will be reviewed for appropriateness of current program by the SDC or her designee by 10/30/06. 10/30/06	

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F 315	Continued From page 6 extend the timed voiding program for an additional 90 days. There was no written indication as to why the resident's timed voiding program had been extended for another 90 days. Data Collection sheets were reviewed for the months of April, May, June and July. The legend on the program data sheets indicated three keys for the bladder component: "C" for continent void, "I" for incontinent void, and "D" for dry. The document further stated that if the resident requested to be toileted that an "R" should precede the key. Analysis of the Bladder Program sheets for these months indicated that the resident had only one continent void for the month of April, 12 continent voidings for the month of May, 6 continent voidings for the month of June and no continent voidings for the month of July. The data also indicated that the resident was almost entirely incontinent for the hours of 2:00 AM, 6:00 AM and 9:00 PM. Some Weekly Progress Notes for the Restorative Nursing Bladder Program indicated percentages of 22-50% of continence for Resident #10. Other notes only stated that the resident had been incontinent. There was no evidence that the data had been analyzed for patterns or trends. In an interview with the Restorative Aide at 10:30 AM on 9/11/06, she stated that she discussed the program at the end of the month with the DON who signed off on the monitoring. When asked where there was documentation of analyzing the data and of changes or revisions, she stated that there was no documentation. There was also no indication of revisions on the care plan for timed voiding. In a meeting with the DON and ADON at 2:30 PM on 9/13/06, the DON indicated that the ADON was in charge of the toileting programs. The	F 315	Updates and careplans will be done as indicated. All nursing staff will be in-serviced by the SDC or her designee on the facility bladder training program by 10/24/06. 10/24/06 Monitoring will be done via monthly reviews done by the SDC or her designee and documented on the weekly review form. See attachment F 315 d Ongoing	

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F 315	Continued From page 7 ADON stated that there was nothing in writing, but that she and the RA discussed the resident. The DON stated that there was no place on the form to document any evaluation. In summary, there was no evidence that the type of urinary incontinence was identified, that there was revision of the care plan as needed, or that there was an evaluation of specific information that determined progress, changes or decline of Resident #10's urinary status. Review of the facility policy regarding the restorative bladder program indicated that there was to be frequent evaluation of the resident's progress, that there was to be a change of interventions based on the assessments and that monthly notes by licensed staff should indicate progress or lack there of. Cross Reference to Tag F282. Resident #14: The resident was admitted to the facility on 12/5/02, with diagnoses including dementia, depressive disorder, osteoarthrosis, anxiety and trigeminal neuralgia. She was alert but cognitively impaired. Resident #14's records were reviewed on 9/12/06. Physician orders for September 2006, indicated the resident was to be placed on a timed toileting program which was to be monitored weekly. Her care plan indicated she was on an individualized bowel and bladder program. The care plan indicated that the toileting program was last reviewed on 8/16/06 and was to continue for 90 days. It also indicated that the program was to be monitored weekly. The facility policy was reviewed and it revealed that the resident's progress or lack of progress	F 315		

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F 315	Continued From page 8 was to be documented by the nurse on a weekly basis along with any adjustments to be made to improve the resident's potential to succeed. Resident #14's records did not reveal that the nurse had addressed the resident's success or lack of success with the program or identified any adjustments to be made on a weekly basis. Resident's #14's record revealed that her percentage of urinary continence ranged from 25.5% continence to 52% continence during June, July and August of 2006. No weekly nursing documentation was found to indicate the resident's performance was evaluated to determine why the resident's performance varied and what interventions might make the resident more successful. An interview with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) on 8/13/06 at 2:30 PM, revealed that the restorative bowel and bladder weekly progress notes were signed by a nurse but there was no place on the form for the nurse to document the evaluation of the Resident #14's performance. Cross reference Tag F282. Resident #7: The resident was admitted to the facility on 10/14/02, with diagnoses including dementia, cerebrovascular disease and a fractured femur. She was cognitively impaired. Resident #7's records were reviewed on 9/12/06. Physician orders for September 2006, indicated the resident was to be placed on a timed toileting program which was to be monitored weekly. Her care plan indicated she was on an individualized bowel and bladder program. The care plan	F 315		

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F 315	Continued From page 9 indicated that the toileting program was last revised on 7/12/06 and was to continue for 90 days. It also indicated that the program was to be monitored weekly. The facility policy was reviewed and it revealed that the resident's progress or lack of progress was to be documented by the nurse on a weekly basis along with any adjustments to be made to improve the resident's potential to succeed. Resident #7's records did not reveal that the nurse had addressed the resident's success or lack of success with the program or identified any adjustments to be made on a weekly basis. Resident's #7's record revealed that her percentage of urinary continence ranged from 22% continence to 62% continence during June, July and August of 2006. No weekly nursing documentation was found to indicate the resident's performance was evaluated to determine why the resident's performance varied and what interventions might make the resident more successful. An interview with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) on 8/13/06 at 2:30 PM, revealed that the restorative bowel and bladder weekly progress notes were signed by a nurse but there was no place on the form for the nurse to document the evaluation of the resident's performance. The ADON indicated that she reviewed the toileting programs at the end of the month, however, there was no documentation found that indicated the Resident #7's performance had been evaluated. Cross reference Tag F282.	F 315		

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F 364 F 364 SS=E	Continued From page 10 483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and resident interviews, it was determined that the facility failed to provide food served at the proper temperature for many residents. Findings include: Based on observation of the Nevada Room dining area on 9/11/06, it was noted that residents were brought in for breakfast at 6:30 AM. When a Certified Nursing Assistant was asked when the breakfast meal was served, she stated at 7:05 AM. When asked why the residents were being brought in so early, she stated that they were given coffee and cocoa and that the time was used to set up the room. At 6:50 AM, it was observed that twelve residents were in the dining room. Only one was observed to have coffee. The majority of the residents were sleeping. At 7:20 AM, it was observed that there were three feeding tables with 7-8 residents per table. There was only one staff person per feeding table. All the trays were uncovered, but only one resident per table was actively being assisted with his meal. At 8:00 AM, it was noted that one resident was asleep with his food, uncovered and untouched. At that time, a staff person came	F 364 F 364	F 364 All residents have the potential to be affected by the deficit practice of failure to provide food served at the proper temperature in the Nevada room. The corrective action is that all the plates of residents who need assistance with meals will be served with the bottom and top plate covers in place. Top covers will be removed when the staff member sits down to assist the resident. All nursing staff will be in-serviced by the SDC or her designee by 10/24/06 Monitoring will occur via temperature checks of sample tray (to be served last) q week x's three months, and prn thereafter. See attachment F 364 a.	10/24/06 Ongoing

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F 364	Continued From page 11 over to assist him, but did not offer him a warm tray. On 9/11/06, the lunchtime meal in the Nevada room was observed from 12:10 PM to 12:45 PM. The following observations were made: Table 2: Resident #17 was observed sleeping from 12:15 PM to 12:35 PM. The lid to her meal plate was off during this time period and she was not eating. At 12:35 PM, a Certified Nursing Assistant briefly and unsuccessfully attempted to awaken her. The resident was observed to remain at the table with her food uncovered and uneaten until 12:45 PM. One Certified Nurses Assistant was observed at Table 2 providing help to seven residents who required assistance to eat. Table 5: Resident #18 was observed to be sitting in front of her uncovered and uneaten meal at 12:20 PM. Her meal remained uncovered and uneaten until a Certified Nurses Assistant went to her table to try to assist her at 12:40 PM. The Certified Nursing Assistant was interviewed and stated that the nurse would be notified of the residents lack of meal intake and that they would make up for it later. Table 7: One Certified Nurses Assistant was observed assisting a table of seven residents who needed help to eat. All meal plate lids were removed while the residents waited for assistance. A second Certified Nurses Assistant was observed to begin helping the residents at Table 7 to eat at 12:40 PM. During the confidential group interview conducted in the facility on 9/12/06, between 10:00 AM and 11:00 AM, four of the six alert and oriented	F 364		

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F 364	Continued From page 12 residents participating, clearly voiced dissatisfaction with the facility's dining room experience. The four residents raised their hands in agreement when asked if they thought the food generally did not taste good and was not hot enough. Three of the residents voiced their concerns that, after being seated in the main dinning room, it was a long wait before the meal was actually served to their tables. The residents also indicated verbally and with a show of hands that it happened frequently throughout the week and it occurred during all three meal times.	F 364		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to serve resident food under sanitary conditions. Findings include: During the observation of the noon meal tray line on 9/12/06, the following were noted: The handwashing sink was observed to have a package of towels lying in it and there was no liner in the garbage can by the handwashing sink. The cook opened the door for this surveyor with gloved hands. He then went back to the serving line without washing his hands and	F 371	F 371 All residents have the potential to be affected by the deficit practice of failure of dietary staff to serve resident food under sanitary conditions. The correction will be accomplished via an in-service to all dietary staff regarding sanitation and infection control by the RD or her designee by 10/14/06. (for in-service, see attachment 371b) Monitoring will be done q week x 4 and monthly thereafter by the RD or her designee via Dietetics sanitation and infection control surveillance form Section 1 Personal standards. See attachment F 371 a	10/14/06 * Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295023	A. BUILDING _____ B. WING _____	09/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON CONVALESCENT CENTER	2898 HIGHWAY 50 EAST CARSON CITY, NV 89701

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F 371	Continued From page 13 changing his gloves. The cook touched the lid to the garbage can. He then went back to the serving line without washing his hands and changing his gloves. The cook was observed holding a plate cover, inside down, against his apron. The tray line server was observed scratching her ear and rubbing her nose. She did not wash her hands or change her gloves before returning to prepare trays. She was also observed to hold glasses and cartons of milk between her arm and her body. The cook was observed to be sweating profusely (about his face) while bending over the open containers of food on the steam table. He would mop his face with his arm. At one point, the dietary manager requested that he leave the steam table to wipe his face. Two desserts were observed leaving the kitchen for distrubution without any covering. Cross Reference to Tag F444.	F 371		10/14/06
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to provide adequate handwashing by kitchen staff to prevent cross contamination during the preparing and serving of resident trays.	F 444	F 444 - See F 371	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295023	A. BUILDING _____ B. WING _____	09/14/2006

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F 444	Continued From page 14 Findings include: During observation of the tray line for the noon meal, on 9/12/06, it was noted that there was a general lack of appropriate handwashing and changing of gloves by the kitchen staff. Cross Reference Tag F371.	F 444		